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HOUSE OF REPRESENTATIVES

REPORT
99-691

ORIGINAL

HIGH RISK OCCUPATIONAL DISEASE NOTIFICATION AND PREVENTION ACT OF 1986

ME203

JULY 17, 1986.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. HAWKINS, from the Committee on Education and Labor, submitted the following

REPORT

together with

SUPPLEMENTAL, MINORITY, AND INDIVIDUAL VIEWS

[To accompany H.R. 1309]

[Including cost estimate of the Congressional Budget Office]

The Committee on Education and Labor, to whom was referred the bill (H.R. 1309) to establish a system for idenfifying, notifying, and preventing illness and death among workers who are at increased or high risk of occupational disease, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE.

This act may be cited as the "High Risk Occupational Disease Notification and Prevention Act of 1986".

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—The Congress finds that—

(1) many toxic and hazardous substances, physical agents, materials, and processes are in wide industrial and commercial use in the United States;

(2) a significant number of workers suffer disability or death or both from occupational diseases caused by hazardous occupational exposures;

(3) diseases caused by hazardous occupational exposures constitute a substantial burden on interstate commerce and have an adverse effect on the public welfare;

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(4) workers have a basic and fundamental right to know they have been and are being exposed to an occupational hazard and are at risk of contracting an occupational disease;

(5) social and family services that reinforce health promoting behavior can reduce the risk of contracting an occupational disease;

(6) there is a period of time between exposure and the onset of disease when it often is possible to intervene medically in the biological process of disease either to prevent or, by early detection, successfully treat many disease conditions;

(7) a significant number of identifiable occupational populations are at risk of developing diseases because of hazardous occupational exposures;

(8) by means of established epidemiological, clinical, and laboratory studies, it is possible to define and identify very specific worker populations at risk of contracting occupational diseases;

(9) there is no established national program for identifying, notifying, counseling, and medically monitoring worker populations at risk of occupational disease;

(10) there is a lack of adequately trained medical and human service professionals, as well as appropriately staffed and equipped health facilities to recognize, diagnose, and prevent occupational diseases;

(11) there is a need for increased research to identify and monitor worker populations at risk of occupational disease; and

(12) through prevention and early detection of occupational disease the staggering costs of medical treatment and care in the United States can be substantially reduced.

(b) PURPOSES.—It is the purpose of this Act—

(1) to establish a Federal program to notify individual employees within populations at risk of occupationally induced disease that they are at risk because of a hazardous occupational exposure, and to counsel them appropriately;

(2) to authorize and direct the certification of occupational and environmental health facilities which have a primary purpose of educating, training, and advising physicians and social service professionals in local communities throughout the United States to recognize, diagnose, and treat occupational disease;

(3) to expand Federal research efforts to improve means of identifying and monitoring worker populations at risk of occupational disease; and

(4) to establish a set of protections prohibiting discrimination against employees on the basis of identification and notification of occupational disease risk.

SEC. 3. DEFINITIONS.

For the purposes of this Act—

(1) the term "employee" means—

(A) any individual employed by an employer, or

(B) any individual formerly employed by an employer as to whom any Federal agency maintains records pertaining to work history, or the employer maintains personnel records, medical records, or exposure records;

(2) the term "employer" means any person engaged in commerce or in an industry or business affecting commerce, or any agency of Federal, State, or local government;

(3) the term "Secretary" means Secretary of Health and Human Services;

(4) the term "population at risk" means an employee population exposed to hazardous occupational exposures within which an associated disease occurs at a rate 30 percent greater than a comparable population not exposed to the hazardous occupational exposure;

(5) the term "hazardous occupational exposure" means—

(A) any harmful chemical, physical, or biological agent found in the workplace;

(B) any industrial or commercial process or activity found in the workplace which is associated with the risk of disease; or

(C) any occupational activity which is associated with the risk of disease;

(6) the term "medical monitoring" means periodic medical examinations of employees who are in a population at risk of occupational disease;

(7) the term "ethical manner" means conduct that recognizes the voluntary nature of the patient-physician relationship and the confidentiality of information communicated in that relationship; and

(8) the term "Board" means the Risk Assessment Board established by section 4 of this Act.

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SEC. 4. RISK ASSESSMENT BOARD.

(a) ESTABLISHMENT.—(1) There is hereby established within the Department of Health and Human Services the Risk Assessment Board. The Board shall consist of 8 members appointed by the Secretary in accordance with paragraph (2) and the Assistant Secretary of Health, who shall serve as chairman.

(2) Of the 8 members appointed by the Secretary—

(A) 5 shall be career or commissioned public health service employees, including an epidemiologist, a toxicologist, an industrial hygienist, a physician, and an occupational health nurse; and

(B) 3 shall be physicians, including an academic physician specializing in occupational medicine, an occupational physician, and a general practitioner.

(3) The members of the Board appointed under paragraph (2)(A) shall be appointed for terms of 5 years, except that—

(A) the terms of members initially so appointed shall expire (as designated by the Secretary at the time of their appointment) at the end of 1, 2, 3, 4, and 5 years, respectively; and

(B) any member appointed to fill a vacancy in the Board that occurs prior to the expiration of a term shall be appointed to serve for the remainder of that term.

(4) The members of the Board appointed under paragraph (2)(B) shall be appointed for terms of one year.

(5) The Secretary shall provide a full-time staff necessary to carry out the functions of the Board.

(b) FUNCTIONS.—(1) The Board shall—

(A) review current medical and other scientific studies and reports concerning the incidence of disease associated with employment;

(B) report to the Secretary on the state of current research with respect to such diseases; and

(C) designate from this review employee populations at risk of disease associated with hazardous occupational exposures, including the size, nature, and composition of the population at risk.

(2) In identifying the populations at risk of disease, the Board shall consider the following factors based upon the best available scientific evidence:

(A) the agents, materials, or processes, or combinations thereof, that may be toxic based upon epidemiologic and clinical observations of human populations, or animal and laboratory studies;

(B) estimates of increased risk of death and disease in specific sites, systems, or organs of the body in exposed human populations; and

(C) estimates of increased risk of death of disease in exposed human populations related to industrial classifications, job categories, and durations of exposure.

(3) The Board shall determine criteria for designating populations at risk in those cases of a rare disease for which the definition in section 3(4) may not be applicable because the disease in question is extremely rare in the general population.

(c) PRIORITIES.—The Board shall undertake, as its first priority, to review employee populations exposed to hazardous occupational exposures whose members are most likely to be helped, either through medical intervention or through counseling on personal health habits. In making this determination, the Board shall consider exposures for which there exists a permanent standard promulgated under section 6(b)(5) of the Occupational Safety and Health Act of 1970 and also shall consider the extent of medical monitoring and surveillance already available to employee populations covered by the permanent standards.

(d) PROCEDURES.—(1) The Board shall initiate a proceeding to identify a population at risk by issuing a notice of its proposed findings and recommendations.

(2) The notice shall—

(A) be published in the Federal Register;

(B) set forth which classes or categories of employees are being considered for inclusion in a population at risk and the reasons for such inclusion;

(C) request the public to submit written views on the proposed findings and recommendations within 45 days; and

(D) provide for a hearing within 30 days after the conclusion of such 45-day period, at which the public may express views on the Board's proposed findings and recommendations.

(3) The Board shall issue final findings and recommendations within 45 days following the hearing, based on the record developed pursuant to paragraph (2) of this subsection.

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(4) If the Board determines that a class or category of employee is a population at risk of disease, it shall make such a finding and, within ten days of making such a finding, transmit to the Secetary a recommendation that the individuals within such a population at risk be notified under section 5 of this Act.

SEC. 5. EMPLOYEE NOTIFICATION AND COUNSELING.

(a) DETERMINATIONS OF THE SECRETARY.—(1) The Secretary shall determine whether a class or category of employees is a population at risk of disease based upon the findings and recommendations made by the Board under section 4 of this Act. The Secretary shall review the findings and recommendations without further notice and without public comment.

(2) The Secretary shall adopt the findings and recommendations of the Board unless the Secretary concludes that—

(A) procedural requirements set forth in section 4(d) are not met, or

(B) to do so will endanger the health and safety of a class or category of employees.

(b) NOTIFICATION OF POPULATION AT RISK.—(1) Upon determination by the Secretary that a given class or category of employee is a population at risk of occupational disease, the Secretary shall notify each individual within such population, and their respective employers, of that risk.

(2) In addition, the Secretary shall make simultaneous use of public service announcements and other means of notification appropriate to reach the population at risk.

(c) CONTENTS OF NOTIFICATION.—The Secretary's notification shall include—

(1) an identification of the hazardous occupational exposure, including the name, composition, and properties of known chemical agents;

(2) the disease or diseases associated with the hazardous occupational exposure;

(3) any known latency periods from time of exposure to time of clinical manifestation of the disease;

(4) counseling appropriate to the nature of the risk including, but not limited to—

(A) the advisability of intitiating a personal medical monitoring program;

(B) the most appropriate type of medical monitoring for the disease associated with the risk;

(C) the name and address of the nearest health center certified under this Act;

(D) the prohibitions against discrimination for notified employees as established under section 8 of the Act;

(E) employer responsibilities with respect to health care for notified employees, as established under section 8 of this Act; and

(F) the telephone number of the hot line established under subsection (d) of this section.

(d) TELEPHONE INFORMATION.—The Secretary shall establish a telephone "hot line" for the employees notified under this section and for their personal physicians for the purpose of providing additional medical and scientific information concerning the nature of the risk and its associated disease.

(e) DISSEMINATION OF INFORMATION.—The Secretary shall prepare and distribute other medical and health promotion materials and information on any risk subject to notification under this section and its associated disease as the Secretary deems appropriate.

(f) ACCESS TO INFORMATION.—In carrying out the notification responsibilities under this section, the Secretary shall, subject to the requirements of section 552a of title 5, United States Code, and other applicable provisions of Federal law, have access to information and data contained in the records—

(1) of any Federal agency solely for the purpose of obtaining names, addresses, and work histories of employees subject to notification under this section; and

(2) of any employer insofar as Federal access is provided for under the Occupational Safety and Health Act of 1970 and the Mine Safety and Health Act of 1977 and regulations promulgated pursuant thereto.

(g) COOPERATION WITH PRIVATE EMPLOYERS AND STATE AND LOCAL GOVERNMENT.—(1) In carrying out the notification responsibilities under this section, the Secretary shall cooperate to the extent practicable with private employers and State and local departments of health and may certify a private employer or a State or local government to conduct notification under this section, pursuant to standards issued by the Secretary. Such standards shall prohibit access by any such employer or govern-

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ment to information and data contained in record described in subsection (f) of this section.

(2) Private employers and State and local departments of health certified by the Secretary to conduct notifications pursuant to subsection (g)(1) of this Act shall assume the costs associated with such notification.

(3) A private employer who has been found to willfully violate a recordkeeping, notification, or hazards communication requirement as promulgated under the Occupational Safety and Health Act of 1970 or the Mine Safety and Health Act of 1977 may not be certified by the Secretary to fulfill the notifications pusuant to subsection (g)(1) for a period of five years after the date of such finding or may have its certification revoked for a period of five years after such finding.

(h) LIABILITY.—The Secretary and agents of the Secretary, including any employer or government acting pursuant to subsection (g) of this section, shall not be liable under Federal or State law for monetary damages with respect to any omission or act performed pursuant to this section.

(i) JUDICIAL REVIEW.—(1) Any person adversely affected or aggrieved by a determination of the Secretary under this Act that a given class or category of employees is a population at risk is entitled to judicial review of that determination in the appropriate United States Court of Appeals upon a petition filed in such court by such person. Any petition filed pursuant to this section shall be filed within 30 days after such determination by the Secretary.

(2) A copy of any petition filed under Secretary by the clerk of the court. The Secretary shall file in the court, as provided in section 2112 of title 28, United States Code, the record of the proceedings on which the determination is based, including the findings and recommendations of the Board and the record of its proceedings.

(3) The court may set aside the determination of the Secretary under subsection (a) of this section only if the determination is found to be—

(A) arbitrary, capricious, or an abuse of discretion;

(B) contrary to constitutional right, power, privilege, or immunity;

(C) in excess of statutory jurisdiction, authority, or limitations; or

(D) without observance of procedure required by law.

(4) The commencement of proceedings under this subsection shall not operate as a stay of the determination of the Secretary to notify employees unless the court specifically orders a stay based upon a determination by the court that the complaining party is highly likely to succeed on the merits.

SEC. 6. HEALTH CENTERS.

(a) SELECTION FROM AMONG EXISTING FACILITIES.—(1) Within 90 days after the effective date of this Act, the Secretary shall establish and certify 10 health centers. The Secretary shall select the 10 health centers from among education resource centers of the National Institute for Occupational Safety and Health and similar facilities of the National Institute for Environmental Health Sciences, the National Cancer Institute, and other private and governmental organizations that apply for such designation by the Secretary. At a later date, but not more than five years after the effective date of this Act, the Secretary shall establish and certify additional health centers from among the health care facilities described in this paragraph so as to obtain no less than one center per State throughout the United States.

(2) Such centers and personnel assigned to them—

(A) shall be selected on the basis of (i) their demonstrated ability and experience in the recognition, diagnosis, and treatment of occupationally related diseases in an ethical manner, and (ii) their capability to offer training and assistance to physicians and social service professionals engaged in the management of populations and individuals at risk of occupational disease, and to fulfill other functions assigned to them under this section, and

(B) shall be certified as such under criteria issued by the Secretary.

(b) FUNCTIONS OF CENTERS.—The centers shall provide education, training, and technical assistance to personal physicians and social service professionals who serve employees notified under section 5 of this Act. The centers also shall be capable of providing research resources, diagnosis, treatment, medical monitoring, and family services for employees notified under section 5 of this Act.

(c) COST OF TRAINING AND EQUIPMENT.—The Secretary shall, from funds appropriated under this Act, reimburse the health centers certified under this section for the cost of developing a training program and procuring specialized equipment required under the certification criteria developed pursuant to subsection (a) of this section.

SEC. 7. RESEARCH, TRAINING, AND EDUCATION.

(a) IMPROVED METHODS OF MONITORING AND IDENTIFICATION.—The Secretary shall, primarily through the health centers established and certified under section 6 of

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this Act, conduct research, training, and education aimed at improving the means of medically assisting employees exposed to occupational health hazards and the means of identifying worker populations exposed to such hazards. Such research, training, and education shall include, but not be limited to, the following areas:

(1) studying the etiology and development of occupationally related diseases and the disabilities resulting from such diseases;

(2) developing means of medical surveillance of employees exposed to occupational health hazards;

(3) examining the medical treatment of workers exposed to occupational health hazards, and means of medical intervention to prevent the deterioration of the health and functional capabilities of employees disabled by occupational disease;

(4) studying and developing medical treatment and allied social services for employees exposed to occupational health hazards;

(5) developing education programs designed to train physicians and social services professionals to assist employees and their families in undertaking measures which ameliorate the effects of those diseases; and

(6) sponsoring epidemiological, clinical, and laboratory research to identify and define additional employee populations at risk of disease from hazardous occupational exposures.

(b) AUTHORITY TO EMPLOY EXPERTS AND CONSULTANTS.—In carrying out activities under this section, the Secretary is authorized to engage the services of experts and consultants as deemed necessary.

SEC. 8. EMPLOYEE TESTING, EVALUATION, MEDICAL MONITORING, AND DISCRIMINATION.

(a) CERTIFICATION OF PROGRAM AVAILABILITY.—An employer who receives a notification under section 5(b) that one or more of its current employees is in a population at risk shall certify to the Secretary that the testing, evaluation, and medical monitoring requested by such employees as a result of the hazard occupational exposure identified in such notification—

(1) will be provided or made available by such employer at no cost to the employee, if any part of such exposure occurred in the course of the employee's employment by that employer; or

(2) will be provided or made available by such employer at a charge to the employee not exceeding the cost to the employer (or at no charge), if no part of such exposure occurred in the course of the employee's employment by that employer.

(b) DISCRIMINATION PROHIBITED.—No employer or other person shall discharge or in any manner discriminate against any employee on the basic that the employee is or has been a member of a population that has been determined by the Secretary to be a population at risk of disease and shall not discriminate against such an employee by refusing to provide for testing, evaluation, and medical monitoring at cost.

(c) BENEFIT REDUCTION PROHIBITED.—If, following a determination by the Secretary under this Act, it is medically determined by the employee's personal physician in consultation with the employer and his medical representative, that such employee should be temporarily or permanently transferred to a less hazardous or nonexposed job, the employee shall retain the earnings, seniority, and other employment benefits as though the employee had not been transferred from the former job.

(d) REVIEW OF COMPLAINTS.—(1) Any employee who is aggrieved by a violation of this section, may, within six months after such violation occurs, apply to the Secretary of Labor for a review of such alleged violation. Upon receipt of such application, the Secretary of Labor shall cause an investigation to be made as he deems appropriate. If upon such investigation the Secretary of Labor determines that the provisions of this section have been violated, he shall bring an action in any appropriate United States district court. In any such action, the United States district courts shall have jurisdiction for cause shown to restrain violations of this section and order all appropriate relief under subsection (e) or (f) of this section.

(2) Within 90 days of the receipt of the application filed under this subsection, the Secretary of Labor shall notify the complainant of his determination under paragraph (2) of this subsection. If the Secretary of Labor finds that there was no such violation, he shall issue an order denying the application.

(e) REINSTATEMENT AND OTHER RELIEF.—Any employee who is subjected to a violation of this section shall be restored to his or her employment and shall be compensated for—

(1) any lost wages (including fringe benefits and seniority);

(2) costs associated with medical monitoring; and

(3) costs associated with bringing the allegation of violation.

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(f) CIVIL PENALTIES.—Any person or institution that violates this section shall be liable for a civil penalty of not less than $1,000 or more than $10,000 for each violation as may be determined by the Secretary of Labor.

SEC. 9. ENFORCEMENT AUTHORITY.

(a) INJUNCTIVE RELIEF.—Whenever the Secretary determines that any person or institution is engaged or is about to be engaged in an act or practice constituting a violation of this Act or any rule or regulation promulgated under this Act, the Secretary may bring an action in the proper United States district court to enjoin such acts or practices, and upon a proper showing an injunction or permanent or temporary restraining order shall be granted without bond. The provisions of section 5(h) shall not limit the authority of the Secretary under this subsection.

(b) EFFECT ON OTHER LAWS.—The notification of an employee pursuant to this Act that such employee is in a population at risk and the initiation of medical evaluation and monitoring shall not constitute or in any way affect a claim for compensation, loss, or damage arising out of the hazardous occupational exposure, except that the results of such medical evaluation and monitoring may be introduced as evidence with respect to such a claim. Notification pursuant to this Act shall not commence the tolling of any statute of limitations with respect to filing a timely claim.

SEC. 10. AUTHORIZATIONS.

There are authorized to be appropriated $25,000,000 for each of the fiscal years 1987 and 1988 to carry out the provisions of this Act.

SEC. 11. EFFECTIVE DATE.

Except as may be otherwise provided therein, the provisions of this Act shall become effective six months after the date of enactment of this Act.

SUMMARY

H.R. 1309, the High Risk Occupational Disease Notification and Prevention Act of 1986, establishes a program within the Department of Health and Human Services that is directed toward reducing and, eventually, eliminating death and disability caused by diseases resulting from exposures to toxic substances and processes in the workplace.

It is estimated that as many as 100,000 workers die each year from occupationally related diseases and as many as 390,000 each year are unable to work because of severe disabilities caused by diseases resulting from exposures to toxic and hazadous substances in the workplace.

Because those diseases have long periods of latency, from as few as five to ten years to as many as 30 and 40 years, scientists believe that medical surveillance is a crucial element in the effort to prevent these diseases from occurring, at best, or in discovering the onset of these diseases at their earliest stages when further medical intervention can be most successful.

H.R. 1309 provides for that medical surveillance. It also provides that current medical, epidemiological, laboratory and clinical studies of occupational diseases and hazardous and toxic substances that meet accepted and recognized scientific standards be used to identify worker population at risk. The worker populations at risk is considered to be those employees in specific job categories and occupational specialties at particular risk of a specified disease if the disease occurred at a rate of at least 30 percent greater within that job category or specialty than in a non-exposed population.

Once identified, current and former workers comprising the specific at-risk population would be individually notified and encouraged to enter a program of testing, evaluation and, most important, medical monitoring and counseling. Once a notified employee de-

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cided to enter into the monitoring program, the cost of that monitoring would be borne by the current employer, if any part of the exposure cited in the notification occurred while the employee was working for that same employer. Otherwise, the employer would be required to provide for the testing, evaluation and monitoring, but could pass those costs on to the employees. Employers are encouraged to use the most cost effective means for providing for the testing, evaluation and medical surveillance.

The combination of medical surveillance to monitor the notified employee's health condition with respect to the disease cited in the notification as well as counseling to encourage positive changes in personal health habits is seen by health professionals as an effective means of action leading to the prevention of occupationally related diseases.

These personal actions, when coupled with new standards for hazardous substances in the workplace, improved engineering systems to reduce exposures and the use of alternate substances, when available, to replace more toxic materials, would offer a great opportunity to prevent these occupationally caused deaths and disabilities. The development and use of sophisticated monitoring systems to enable the collection of workplace exposure levels also will contribute to the expansion of knowledge in this area.

LEGISLATIVE CONSIDERATION

H.R. 1309 was introducted on February 27, 1985, by Congressman Gaydos and Congressman Hawkins and was referred jointly to the Subcommittee on Health and Safety and the Subcommittee on Labor Standards. A joint oversight hearing by the two subcommittees on the issue of worker notification was conducted on July 17, 1985, and five legislative hearings on the bill were conducted on October 9, November 6, 13 and 20, 1985, and March 19, 1986, to take testimony from the business community, labor, Federal and State government agencies, health professionals and the insurance industry.

H.R. 1309 was considered by the Subcommittee on Health and Safety and on Labor Standards on May 14, 1986, and an amendment in the nature of a substitute was favorably reported by a vote of 5–1 in the Subcommittee on Health and Safety and a vote of 4–2 in the Subcommittee on Labor Standards. H.R. 1309 was considered by the Committee on Education and Labor on June 25, 1986, and was reported favorably as amended by a vote of 20–8.

NEED FOR THE LEGISLATION

In 1775, a prominent British surgeon was the first to note that chimney sweeps suffered a high frequency of cancer of the scrotum. Upon further study, Dr. Percivall Pott determined that the reason for this increased incidence of cancer among chimney sweeps was their prolonged exposure to and repeated contact with soot.

Since Pott's discovery of the relationship between workplace exposures and disease, scientists have found that many workers in today's highly industrialized society have been and are being exposed to a wide range of toxic substances, materials and processes that have resulted in death and disability from such occupationally

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related diseases as cancer, heart disease, nervous system and brain disorders, respiratory illnesses, reproductive damage, and others.

We know that exposure to asbestos will lead to a variety of lung disorders; that exposure to benzene can lead to leukemia; that exposure to certain dye chemicals will result in cancers of the bladder and urinary tract; that exposure to vinyl chloride can result in cancer of the liver or brain; and that exposures to other substances can lead to other diseases that may result in death or disability.

We know that these diseases develop only after periods of latency that range from five to ten years to as much as 30 or 40 years and that even when a standard that establishes exposure levels is put in place, it only affects the health and safety of current employees, not those formerly exposed who would be at the greatest risk of disease.

We even know that existing medical, scientific and engineering techniques can lead to the prevention of these diseases or, at the very least, lead to their discovery in the earliest stages when treatment can be most successful.

Still, for all our knowledge about the many disease-causing agents in the workplace and our knowledge about the specific worker populations and subpopulations that are at greatest risk of getting those diseases, we are no further along in preventing the onset of those diseases than Dr. Pott was.

As Dr. Irving Selikoff of Mount Sinai School of Medicine in New York City testified during an oversight hearing before the Subcommittees on Health and Safety and on Labor Standards on July 17, 1985, with regard to workplace-related diseases:

> * * * Well, there were three phases to what existed. The first was, we could identify things that killed people, caused disease; second, we knew how to find these—the epidemiological methods, the population studies, the laboratory investigations, and so forth.
>
> So here were, able to find what was causing disease, knowing that when we found these things it would help prevent those diseases.
>
> The third phase, however, was never completed, and that was to use the knowledge that we now had and could have and will have * * *
>
> Yet here we were, people who were exposed to coal dust still dying of coal workers' respiratory disease, people exposed to arsenic still dying of lung cancer, nobody doing very much about it, asbestos workers dying of mesothelioma and lung cancer and asbestosis just as if we had not done 50 years of research, silicosis taking many people as if they had respiratory infections, people dying of bladder cancer having been previously exposed to benzidine and beta-Naphthylamine, and it is a very disheartening situation. We are not using the information we have. That's almost worse than not having the information * * *

Since 1913, physicians and state and local health departments have been required to report on a number of infectious diseases. The result of this reporting has been to focus the medical and scientific community on finding means of treating the illness and,

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eventually, to eliminating them. The results speaks for themselves. While cases do arise, virtually all of the infectious diseases on the early reporting lists have been eliminated or substantially controlled.

No similar system exists for reporting deaths, diseases, and illnesses resulting from occupational exposures. In testimony presented to the Subcommittee on Health and Safety on July 24, 1985, Dr. J. Donald Millar, Director of the National Institute for Occupational Safety and Health (NIOSH), conceded that hard data on occupational diseases, deaths and illnesses was difficult to come by since there was no requirement for reporting these deaths, diseases, and illnesses as there was for infectious diseases.

Admitting the 75-year lag, Dr. Millar noted that NIOSH was making some effort to stimulate and encourage states to include information about occupationally related illnesses, diseases and deaths in their reports, but there was no intention of requiring state departments of health to provide the data.

Dr. Millar, in that same testimony, implied that NIOSH had devoted considerably more effort and focus on occupational disease rather than occupational safety, yet the agency was still using estimates on deaths and disabilities resulting from occupationally caused disease offered in the President's Report on Occupational Health and Safety of 1972, which noted:

> The incidence of occupational disease is less well known, but recent estimates indicate that at least 390,000 new cases of disabling occupational disease (arise) each year. Based on limited analysis of violent/nonviolent mortality in several industries there may be as many as 100,000 deaths per year from occupationally caused diseases. Health deterioration at the workplace results from a variety of hazards and manifests itself in a variety of forms. These range from the overt, classic, occupational diseases such as lead and mercury poisoning, to the insidious, delayed effects of exposure to noise that cause partial or total hearing loss and to dusts that produce fibrosis of the lungs. Even beyond these effects, there are considerations that exposures to some occupational hazards will cause, promote, or contribute to the development of cancer, hasten the onset of certain degenerative diseases, or shorten the life span.

Even beyond the general numbers, we have estimates of the numbers of workers exposed by many of the substances. And, while not all of the estimates by different groups agreee completely, there is ample similarity. For example, just comparing the estimates by NIOSH and the Industrial Union Department of AFL-CIO for potentially exposed workers to the substances for which the Occupational Safety and Health Administration (OSHA) has promulgated permanent standards shows some differences, but even NIOSH admits that its figures, based on the National Occupational Hazard Survey of 1972–74, probably underestimate the number of exposed workers.

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Substance	NIOSH	IUD
asbestos	450,456	2,479,900
coal tar	78,765	.....
4-nitrobiphenyl	(1)	(2)
alpha-naphthylamine	610	46,400
4,4-methylenebis	2,094	67,200
methyl chloromethyl ether	(1)	(2)
3,3' cichlorobenzidine	(1)	(2)
bis-chloromethyl ether	(1)	(2)
beta-naphthylamine	420	1,000
benzidine	1,166	1,200
4-aminodiphenyl	(1)	(2)
theyleneimine	1,712	4,500
beta-propiolactone	38	(2)
2-acethylaminofluorene	(1)	(2)
4-dimethylaminoabenzene	588	28,600
N-nitrosodimethylamine	(1)	(2)
vinyl chloride	29,836	3,546,700
inorganic arsenic	9,767	1,491,700
lead	103,275	(3)
coke oven emissions	(4)	10,000
cotton dust	460,767	(5)
1,2-dibromo-3-chloropropane	176	(2)
acrylonitrile	55,698	125,000
ethylene oxide	107,450	100,000

[1] NF—not found.
[2] E—less than 1,000.
[3] NSE—no satisfactory estimate.
[4] Not identifiable.
[5] No estimate.

No less serious is the knowledge that even when worker populations at risk have been identified, as NIOSH has done, either the efforts to notify those workers of their risks have been thwarted or no efforts have been made.

NIOSH, for example, knows the names and locations of some 250 workplaces in this country where as many as 250,000 current and former workers face increased risk of diseases such as cancer, lung disease, and other health problems because of exposures to asbestos, polyvinyl chloride, PCBs, lead, benzene, and a variety of other toxic substances. The data was obtained by NIOSH from 66 mortality studies conducted over a period of years ending in January, 1982.

In an expansion of that work, NIOSH identified three categories of workers who might be eligible for notification, even though it was not an aim of the NIOSH studies. The three categories are:

Group A (86 work sites, 110,005 workers): "Studies in which participants could gain direct medical/health benefits from notification."

Group B (136 work sites, 137,967 workers): "Studies in which participants are potentially at high risk and should be notified but there are no effective intervention methods."

Group C (27 work sites, 6,508 workers): "Studies in which individual participant notification would stimulate improvements in working conditions."

In 1983, NIOSH drafted a proposal for a pilot worker notification project aimed at notifying some 25,000 workers of their particular risks of disease. The targets of the proposed program were:

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8,000 workers at four locations in the beryllium industry who were found to have excess rates of lung cancer, heart disease, and nonmalignant respiratory disease.

10,000 chemical workers at six locations whose exposure to bis-chloromethyl ether placed them at excess risk of lung cancer.

2,300 workers at four locations who were exposed to benzidine and betanaphthylamine.

321 oil shale workers who showed a statistically significant risk of keratosis.

5,000 uranium miners and millers at 300 locations who were at increased risk of lung cancer and other diseases.

The Centers for Disease Control submitted a budget request for $4 million for the NIOSH notification program, but the request was rejected in late 1984 by the present Administration.

Further, NIOSH has already participated in some pilot notification programs, indicating that the techniques for identifying worker populations at risk and for notifying those workers individually exist and have been proven to work.

In 1980, NIOSH conducted a pilot notification project in Augusta, GA. In this program, NIOSH identified a cohort of 1,385 workers who were at risk of bladder cancer because of exposure to BNA. A key part of the program was a bladder cancer screening and educational program set up by a coalition of state and local health departments, a medical college and a community action group.

NIOSH was able to locate and notify 849 of 1,100 surviving workers, including more than 200 who had moved and had to be tracked through a variety of means.

In reviewing the program, the NIOSH report noted:

> * * * Individual worker notification is merely the first step in a long and complex process. It (the pilot study) confirmed that notification can be achieved, but there is a need for subsequent provision of information, for medical surveillance, and for support programs for those notified and sometimes for their families. Although, as would be expected, the workers found the news of their risk quite distressing and learned all too quickly that the workers' compensation system would be inadequate to provide for their needs, there has been little evidence observed to date of psychopathologic effects resulting from this notification program.
>
> The Augusta Study also included an evaluation of the assumptions implicit in a notification program, and more specifically it addressed the question of whether the results were applicable on a clinical or individual basis. It was concluded from the study that such information is applicable to individuals.

Today NIOSH says those workers shouldn't be notified because to do so would create confusion and chaos, instilling fear among those workers who would receive individual notices from the government that they were at risk of a specific disease or diseases because of their exposures.

A third factor complicating efforts to prevent occupational disease, or even to increase awareness to it, is the time lag between the worker's exposure to the disease-causing substance in the work-

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place and the onset of the disease itself. As the chart following shows, in some cases, diseases related to workplace exposures appear as early as five or ten years, but in many others, the time between the exposure and the onset of the disease may be 30, 40, or 50 years.

Agent	Occupation	Body region affected	Approximate time lag (years)
Arsenic	Miners, chemical workers	Skin, liver, lungs	10+
Asbestos	Textile, insulation, shipyard workers	Lungs, gastrointestine	4–50
Benzene	Distillers, shoemakers	Bone marrow	6–14
Chromium	Glass, linoleum workers	Nasal cavity	15–25
Dyes	Dye and rubber workers	Urinary tract, bladder	13–30
Vinyl chloride	Plastic workers	Liver, brain	20–30

Source: "Lifeguard," Newsletter of Rancho Enciono Hrspital, Encino, CA

This time lag between the exposure to the disease-causing substance and the onset of the disease poses a serious diffculty in attributing the disease. Too often, physicians who are diagnosing the disease are not experienced enough in occupational medicine to draw the kinds of conclusions that Dr. Pott did in observing the incidence of cancer of the scrotum among chimney sweeps in late eighteenth century England. Secondly, it is unlikely that a physician would ask his patient to provide an occuputional history as well as a medical/health one.

Medical surveillance coupled with counseling as to personal health habits is, in the view of Selikoff and other witnesses, the most positive step in the drive to eliminate and prevent occupational diseases. Notified workers, in the first place, will be far more aggressive in ensuring that the exposure that led to their notice of increased risk is diminished or ceased. This may lead to better engineering controls that will reduce the exposure levels, to the use of alternate substances that might not be as personally toxic, to the development of better personal safety equipment and reduced acceptable levels of exposure.

Further, medical surveillance and counseling on personal health habits will lead to earlier detection of disease, should it occur at all, providing opportunities for more successful treatment at a lower cost.

A number of cancer specialists believe that the national war on cancer is not as successful as it might be. These specialists argue that prevention and early detection of cancer are the most significant means of eliminating it from society.

Dr. Arnold H. Muller, Pennsylvania Secretary of Health, agrees that early detection of cancer is doubly valuable. First, early detection of cancer leads to earlier treatment of the disease with a much stronger likelihood of success. Second, early detection is substantially cost effective.

Dr. Muller noted that the cost of treating an advanced case of cervical cancer averaged about $35,000. Through early detection, the same case, discovered early, could be treated for about $500, a differential of 70 times.

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In addition, modification of personal habits, such as the elimination of tobacco or alcohol, can lessen the intensity of a disease once it becomes visible.

During hearings on H.R. 1309, witnesses representing business, industry, and the current Administration, while expressing compiete support for the concept of notifying workers of their risks of working with hazardous substances, opposed the bill and stated that the Hazard Communication Standard, promulgated by the Occupational Safety and Health Administration (OSHA) in 1983, provided ample information and protection for workers dealing or coming into contact with hazardous substances.

The Hazard Communication Standard, as it presently stands, went into effect in part on November 25, 1985, and in toto on May 25, 1986. It presently covers only workers in the manufacturing sector. Court rulings in June of 1985 ordered OSHA to expand coverage of the standard to all workers and required OSHA to revise the "trade secrets" provision of the standard which allows manufacturers to withhold certain information in the interest of protecting their investments. OSHA has not yet complied with the court ruling.

Under the standard, manufacturers and importers of hazards substances are required to provide labels and material safety data sheets for hazardous substances, informing users and their employees of certain hazards with regard to the specific substance. The material safety data sheets, in particular, are to be available for employees in the workplace and are to provide information with regard to the make-up of the substance, its properties, the permissible exposure levels, the acute and chronic health effects, and other data.

One of the difficulties with the material safety data sheet is that it is prepared by the manufacturer or importer of the chemical or combined substance. While it is unlikely there would be a deliberate effort to exclude certain data, it is clear from studies already completed that errors of commisison and omission abound. The California Occupational Safety and Health Administration reviewed some 20,000 material safety data sheets prior to the effective date of the Federal standard and discovered that 80 percent contained errors. Most of those errors, furthermore, were failures by preparers to include data with regard to chronic health dangers.

More recently, speakers at an American Chemical Society meeting in New York City noted the wide disparity between material safety data sheets from different preparers for the same substance. In some instances, known carcinogens were not so cited on the sheets, while in some instances they were.

OSHA, despite its own testimony as to its capability to review material safety data sheets, does not have adequate numbers of skilled persons to review every material safety data sheet prepared. And, unless the error is so glaring, field inspection personnel are unlikely to know how accurate the material safety sheet is.

But, more to the point, the Hazard Communication Standard is designed to tell workers of the hazards of the chemicals they work with, not their risk of disease from exposures to these chemicals, the thrust of H.R. 1309.

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There is no requirement within the standard to inform either current or former workers of the levels of exposure in the workplace nor to conduct medical examinations of workers exposed to hazardous substances. There is no attempt to focus specifically on workers in those job categories, functions or specialities that are at particular risk.

For example, before OSHA promulgated its standard on coke oven emissions, scientists knew that those employees working on the top of the coke ovens, where emissions were greatest, were at far higher risk of the diseases associated with those emissions. Under the provisions of H.R. 1309, those coke oven workers would be identified and notified.

There is no requirement that medical surveillance be provided for those workers who are exposed to determine their health and the impact of the exposures over a period of time.

Some references also were made to the Environmental Protection Agency's role under the Toxic Substances Control Act (TSCA). Section 8(e) of TSCA requires all chemical manufacturers, processors, and distributors to notify EPA immediately when they obtain information indicating that a chemical poses a substantial risk of harm. There is no requirement that the workers who are exposed to these chemicals or those who were the subjects of studies of these chemicals be informed as to their risks.

During the course of actions by the Subcommittees on Health and Safety and on Labor Standards and the Committee on Education and Labor, H.R. 4793 was offered as an amendment in the nature of a substitute. H.R. 4793 provides a statutory base for OSHA's Hazard Communication Standard and expands the standard's range to include all industry and would require employers to notify former employees of all hazardous substances with which they worked, but only if so requested.

This substitute fails in comparison to H.R. 1309. First, it does not provide for the identification of specific worker populations and categories, such as those coke oven workers who would be at greatest risk, does not provide for individual notification to either former or current workers of their individual risks of disease, is silent on the question of medical evaluation and surveillance, and provides only a vague definition of hazard that will make compliance for employers far more difficult and unreasonable.

More than 50 years ago, in his report to New York Governor Franklin D. Roosevelt, the State Commissioner of Health expressed concern about the new chemical compounds being developed and the need for workers to know about the risks involved in working with those substances. Further, the Commissioner recommended medical examinations for workers at risk to meet four needs: early detection of disease so that its treatment could be enhanced: assistance in safeguarding the workplace; protection of workers and the public from economic disaster; and to guide employees in career selection.

Nearly 10 years ago, in 1979, seven years after Congress passed the OSHAct, former Senator Jacob Javits of New York posed the following question during a Senate hearing on worker deaths and disabilities from occupational exposures: "Could we not standardize the matter of examinations for workers who are within a hazard-

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ous environment? We certainly know that there are hazardous environments, could we require an annual examination of workers to deal with the particular hazards that they are faced with within their occupational environment?"

The answer to that question was provided by Dr. Vernon Rose, then Director of the Division of Criteria Documentation Standards Development at NIOSH: "Yes, Mr. Senator, . . . you created the Act (OSHAct) to identify that a standard is not just an environmental limit, such as 200 micrograms of cotton dust, but may include other factors, even medical examinations . . ."

EXPLANATION OF THE BILL

H.R. 1309 establishes a system for identifying and notifying workers of their risk of disease because of exposures to any of a variety of toxic substances in the workplace. The bill creates a Risk Assessment Board of Public Health Service Professionals who will review epidemiological and other studies in order to designate specific occupational groups that are at risk of those diseases by virtue of the jobs they hold.

The Risk Assessment Board would report its findings to the Secretary of Health and Human Services who would then develop a program to individually notify the workers in the specific occupational group and their employers.

The bill provides for the development of a series of health centers which would provide training and education services for physicians monitoring the health of notified workers. The centers would expand from an initial 10 to at least 50 over a five year period.

Insofar as notified workers are concerned, once notified, it would be up to the individual worker to initiate the program. If desired, a worker would be tested for the specific disease for which he or she is at risk and would be placed in an appropriate monitoring program (X-rays for some diseases, blood tests or other kinds of tests depending on the disease). In addition, there would be counseling to assist the notified worker about other personal habits, including smoking, diet, exercise, etc., that might reduce the effect of the disease, should it arise.

The cost of the testing, evaluation and monitoring programs would be borne by the employer responsible for any part of the hazardous exposure, in the case of current workers.

The bill also includes provisions against discriminating against notified employees except to state that notification is not sufficient reason for a workers' compensation claim, but does not start the clock on workers' compensation statutes of limitation.

The bill provides for an authorization of $25 million for each of the first two years.

The specific provisions H.R. 1309 are described in detail in the section-by-section analysis of the bill. Certain elements, such as the Risk Assessment Board, the health centers and the employers' role, however, merit highlighting.

Risk Assessment Board

H.R. 1309 creates a nine-member Risk Assessment Board which has the critical task of applying the criteria specified in the bill to

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identify those specific work populations and subpopulations that meet the criteria and should be notified.

Five of the nine members of the Board are career or commissioned officers in the Public Health Sevice with specialties in epidemiology, toxicology, industrial hygiene, medicine, and occupational health nursing. Although not specifically cited, the Board would benefit if one of the members or a member of the Board staff, to be provided by the Secretary of Health and Human Services, had a background in biostatistics.

These particular qualifications would provide a range of scientific and medical knowledge capable of evaluating the epidemiological, clinical and laboratory studies by NIOSH and other governmental agencies and private research organizations for their accuracy, relative scientific value, applicability to the identification process, and biological plausibility.

The three nongovernmental physicians to serve on the Board provide a more practical medical expertise in terms of actual occupational health activities, but without injecting political elements into the proceedings and actions of the Board.

The hearing process, which includes a period of written comment and public hearing between the Board's issuance of proposed findings and recommendations and its submission of final findings and recommendations, focuses on the scientific aspects of the Board's actions. In its process of identifying worker populations at risk, the Board, in using epidemiological studies, would consider workers performing the same or similar functions as the study cohort being exposed to the same toxic substances or processes, but would not necessarily require that all workers in a single plant be classified at risk.

In order to be identified as a population at risk by the Board, an employee population under consideration would have to experience a rate of disease no less than 30 per cent greater than in a nonexposed population.

The 30 percent limit is the floor except for certain diseases that are rare or appear in the general population so rarely as to be determined under a separate criteria to be developed by the Board itself.

The 30 per cent trigger is a conservative one. While some epidemiologists believe a 20 percent increase is significant, many more regard a 30 per cent increase as being of statistical significance.

Health centers

The 10 health centers that will be established initially will be the primary source of assistance to physicians and health and social service professionals working with notified workers and their families.

In addition to providing education, training and assistance, it is possible that an employer required to provide testing, evaluation and medical surveillance for a notified employee, might wish to contract with a nearby health center to conduct those activities. Further, in order to provide experience for physicians working in occupational medicine who will be working with notified employees, the health centers will have to have the capacity to treat workers who develop occupational diseases.

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This capability also will be necessary so the health centers can better understand and develop medical surveillance procedures.

It is expected that the initial 10 health centers to be established can be developed from among the 15 Education Resource Centers funded by NIOSH; the 51 occupational health clinics spread across the country and, generally, associated with a university medical school or teaching hospital; NIEHS centers, National Cancer Institute centers, and others operated with private and public funds.

Further, the Centers for Disease Control (CDC) is currently accepting grant applications to establish centers for research and demonstration of health promotion and disease prevention. CDC has about $1.4 million currently and will provide awards ranging between $250,000 and $750,000. Eligibile applicants are schools of medicine, public health and osteopathy, including existing consortia.

Employer responsibilities

The Secretary of Health and Human Services has the responsibilities for individually notifying those workers within the populations at risk identified by the Risk Assessment Board. The contents of the notification are specified in the language of the bill.

As a response to testimony by some private employers that already have in-house notification programs, the Secretary may certify a private employer to conduct the notification process, at the request of the private employer.

The only responsibilities employers must assume are to certify to the Secretary, after they and their employees are notified, that there is a program in place to provide for the testing, evaluation, and medical monitoring of the notified employees and to provide for the testing, evaluation and medical monitoring.

Insofar as costs, employers will be responsible for assuming the costs of testing, evaluation and medical monitoring only for those of its current employees who were exposed while working for that employer. In other instances, where the current employer was not the employer of record when any part of the exposure occurred, the employer is to make the testing, evaluation and medical monitoring services available to notified workers, but may pass those costs along to those workers.

Further, with respect to providing for testing, evaluation, and medical monitoring, employers are encouraged to seek the most cost effective means of affording these services to notified employees, regardless of whether the costs of such services are to be assumed by the current employer or passed on to the employee.

It may be most economical for an employer to acquire additional coverage from his current health insurance carrier in order to assume the costs or it may be more economical for the employer to seek some other means, such as a contractual agreement with a health maintenance organization, a prviate or public clinic, a testing laboratory, or a hospital, for providing the services. Some employers might find that the most economical method would be to create or expand an existing in-house medical/health program. Nothing here should be construed as to require an insurance carrier, a HMO or any other source to provide the testing, evaluation or monitoring services.

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It should also be noted that there is nothing in H.R. 1309 that mandates that a notified person be required to enter into the recommended program of testing, evaluation and medical monitoring.

OVERSIGHT

No findings or recommendations concerning oversight of the program created in this bill have been received by the Committee form the Committee on Government Operations. The provisions of H.R. 1309 are based upon findings from the Education and Labor Committee's ongoing oversight of existing programs.

ENERGY AND COMMERCE COMMITTEE COMMENTS

An exchange of letters between Chairman Hawkins of this Committee and Chairman Dingell of the Committee on Energy and Commerce follows:

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC, July 16, 1986.

Hon. AUGUSTUS F. HAWKINS,
Chairman, on Education and Labor,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Committee on Education and Labor has recently ordered reported H.R. 1309, the High Risk Occupational Disease Notification and Prevention Act of 1986.

This legislation establishes a program within the Department of Health and Human Services that will address issues of work-place exposure to hazardous substances. Aspects of this legislation fall within the jurisdiction of the Committee on Energy and Commerce.

The Committee on Energy and Commerce has conferred with the Committee on Education and Labor relating to the issues of acknowledged jurisdictional concern, and this Committee is satisfied with the legislation. As a result, the Energy and Commerce Committee will not request referral on this bill.

This action should not be construed as relinquishing this Committee's jurisdictional claim in this area. I respectfully request that this letter be made a part of the House Report on H.R. 1309.

I am grateful for your continued cooperation on this matter of great importance to the health of American workers.

Sincerely,

JOHN D. DINGELL, *Chairman.*

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON EDUCATION AND LABOR,
Washington, DC, July 16, 1986.

Hon. JOHN D. DINGELL,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: Thank you for your letter regarding H.R. 1309, the High Risk Occupational Disease Notification and Prevention Act, which has been ordered reported by the Committee on Education and Labor.

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H.R. 1309 was referred solely to the Committee on Education and Labor under House Rule X(1)(g) which gives the Committee jurisdiction over legislation relating to labor. Nonetheless, I acknowledge your concern that certain provisions in the bill may affect the jurisdiction of the Committee on Energy and Commerce, and appreciate your cooperation in reviewing those provisions without requesting sequential referral of the bill. Furthermore, I understand and agree that such action shall not be construed as an abdication of any possible jurisdictional interest of the Committee on Energy and Commerce. Your letter and this response will be included in the Committee's report on H.R. 1309.

Thank you for your interest and cooperation in our continuing efforts to protect the health of American workers.

Sincerely yours,

AUGUSTUS F. HAWKINS, *Chairman.*

COST ESTIMATE

The Congressional Budget Office has estimated that there will be the following costs to the Federal government in implementing this legislation. The Committee concurs in these estimates and adopts them in compliance with clause VII of Rule 13. No cost estimates have been received from any any other Federal department or agency.

The CBO letter follows:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC July 10, 1986.

Hon. AUGUSTUS F. HAWKINS,
Chairman, Committee on Education and Labor,
Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for H.R. 1309, the High Risk Occupational Disease Notification and Prevention Act of 1986, as ordered reported by the House Committee on Education and Labor on June 25, 1986.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,

Sincerely,

RUDOLPH G. PENNER, *Director.*

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: H.R. 1309.

2. Bill title: High Risk Occupational Notification and Prevention Act of 1986.

3. Bill status: As ordered reported by the House Committee on Education and Labor on June 25, 1986.

4. Bill purpose: To establish a system for identifying, notifying, and preventing illness and death among workers who are at increased or high risk of occupational disease, and for other purposes.

5. Estimated cost to the Federal Government:

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[By fiscal year, in millions of dollars]

	1987	1988	1989	1990	1991
Estimated authorization level	25.0	25.0			
Estimated outlays	15.8	22.4	8.6	2.6	0.6

Basis of estimate: The authorization level for the entire Act is stated in the bill for fiscal years 1987 and 1988. CBO assures all authorized amounts are fully appropriated at the beginning of each fiscal year. Outlays are estimated using spendout rates computed by CBO on the basis of similar health service program data. Authorization levels are subject to subsequent appropriations action.

This bill would establish an eight member Risk Assessment Board to designate employee populations at risk of occupational disease. Based on the Board's findings, the Secretary of Health and Human Services would have the authority to declare certain employee groups at risk. Individuals in the group and their employers would be notified either by the Secretary or by private employers or state or local governments certified by the Secretary to conduct notification.

The bill would also establish ten health centers from among existing education resource centers and similar facilities within the federal and private sectors. These centers would provide health care services to employees notified as being at risk of occupational disease. Centers would also conduct research and provide education, training, and technical assistance to physicians and social service professionals serving these employees. Costs associated with training and equipment for the centers would be funded from appropriations authorized by this Act. Notified employees would be required to pay the costs of employee testing, evaluation and medical monitoring if hazardous exposure occurs while under their employment. They would be required to make such services available at cost if employee exposure did not occur while under their employment. The bill does not specify who would pay the cost of any necessary treatment.

Within five years of the effective date of this Act, the Secretary would be required to establish at least fifty additional health centers. However, no appropriations are authorized in the bill beyond fiscal year 1988.

6. Estimated cost to State and local government. The budgets of state and local governments could increase as a result of enactment of this legislation. The bill states that the Secretary may certify a state or local government to conduct notification of risk of occupational disease. State and local departments of health so certified would, under the bill, pay the costs associated with notification. However, CBO has no basis to estimate the number of state or local governments that might be certified by the Secretary or the costs to them of notification. In addition, the bill would require employers to pay for testing, evaluation and medical monitoring if their employees are exposed to occupational hazards while on the job. If a state or local government were such an employer, their budgets could be expected to increase to cover these costs.

7. Estimate comparison: None.

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8. Previous CBO estimate: None.
9. Estimate prepared by: Carmela Dyer.
10. Estimate approved by: James L. Blum, Assistant Director for Budget Analysis.

INFLATIONARY IMPACT

Since funding for each of the first two years will involve modest costs to the Federal government and since costs in future years will continue to be modest, the Committee estimates this bill has no significant inflationary impact.

SECTION BY SECTION ANALYSIS

Section 1. Short title

The bill, when enacted, shall be cited as the "High Risk Occupational Disease Notification and Prevention Act of 1986."

Section 2. Findings and purposes

Subsection (a) finds that workers have a basic right to know that they are at risk of disease because of exposures to many toxic and hazardous substances and processes in the workplace; that many workers suffer death and disability because of the diseases caused by those exposures; that many of these diseases have long periods of latency when medical intervention can prevent the onset of the diseases; and that a combination of medical surveilance and counseling on personal health habits can significantly reduce the intensity of the disease or prevent it entirely.

Subsection (b) states that the purpose of the bill is to notify individual workers within populations at risk that they are at risk; certify health centers which would educate, train and advise physicians working with notified workers; expand research into occupational diseases; and prohibit discrimination against notified workers.

Section 3. Definitions

An employee is defined as either a current or former employee; the Secretary is the Secretary of Health and Human Services; a population at risk is an employee population exposed to a hazardous occupational exposure within which an associated disease occurs at a rate at least 30 percent greater than in a comparable nonexposed population; a hazardous occupational exposure is defined as any harmful agent, process, or occupational activity which is associated with a particular disease.

Section 4. Risk Assessment Board

Subsection (a) establishes a nine-member Risk Assessment Board composed of the Assistant Secretary of Health as chairperson, five career or commissioned Public Health Service officers with particular medical and scientific specialities; and three nongovernment physicians.

Subsection (b) directs the Board to review current medical and scientific studies and research reports concerning occupational diseases and to designate employee populations at risk of diseases con-

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sidering such factors as agents, materials or processes that may be toxic based on the studies and research, estimates of increased risk in systems and organs of the body, and estimates of increased risk related to industrial classifications, job categories, and durations of exposure.

Subsection (c) provides that the Board will take as its priorities those exposed employee populations whose members are likely to be helped through medical intervention or counseling as well as those workers exposed to substances for which the Occupational Safety and Health Administration has promulgated a permanent standard under the OSHAct of 1970.

Subsection (d) provides for a hearing process once the Board's proposed findings and recommendations are published in the Federal Register. The hearing process shall include a period for written comment, and a public hearing before its final findings and recommendations are transmitted to the Secretary.

Section 5. Employee notification

Subsection (a) provides that the Secretary shall adopt the findings and recommendations of the Risk Assessment Board unless certain conditions are not met.

Subsection (b) requires the Secretary to notify employees and their employers in the identified population at risk individually and through public service announcements and other means.

Subsection (c) provides that notifications include an identification of the hazardous occupational exposure, the disease or diseases associated with it, latency periods if known, counseling and medical monitoring programs appropriate for the disease, and the employer's responsibility.

Subsection (d) creates a toll-free hot line for notified persons and their physicians for providing additional information.

Subsection (e) provides for the dissemination of health promotion materials and information on any risk subject to notification.

Subsection (f) allows the Secretary access to certain information held by Federal agencies insofar as allowed by applicable law.

Subsection (g) provides that the Secretary may certify private employers and state and local governments to assist in worker notifications, but prohibits access to federal information by those private employers and state and local governments.

Subsection (h) relieves the Secretary and any agents of the Secretary from liability for monetary damages with regard to omissions or acts in the notification process.

Subsection (i) provides for petition to the appropriate United States Court of Appeal by any person believed to be adversely affected or aggrieved by the Secretary's notification action.

Section 6. Health centers

Subsection (a) provides that the Secretary will certify 10 health centers from among the already existing education resource centers of NIOSH, NIEHS centers, National Cancer Institute centers, and other private and governmental organizations that apply. Within five years, 50 centers, with at least one in each State, shall be certified.

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Subsection (b) provides that the centers offer education, training and technical assistance to personal physicians and health and social service professionals and be capable of providing research resources, diagnosis, treatment, medical monitoring and counseling.

Subsection (c) permits the Secretary to reimburse centers for those costs directly related to meeting the certification criteria.

Section 7. Research, training and education

Subsection (a) provides that the Secretary, primarily through the health centers, conduct additional research aimed at improving the means of medically assisting notified employees and the means of identifying worker populations by studying the occupationally related diseases and the disabilities resulting from them, examining medical monitoring procedures as well as treatment of workers exposed to occupational hazardous substances.

Subsection (b) provides that the Secretary may hire experts and consultants.

Section 8. Employee testing, evaluation, medical monitoring and discrimination

Subsection (a) provides that employers notified that one or more current employees is in a population at risk shall certify to the Secretary that testing, evaluation and medical monitoring requested by the employee either will be provided at no cost to the employee if the current employer is responsible for any portion of the exposure, or will be provided or made available at a charge to the employee if no part of the exposure occurred while in that employ.

Subsection (b) prohibits the discharge of or discrimination against any employee that is or has been determined to be in a population at risk.

Subsection (c) permits either permanent or temporary transfer of an employee to another job without loss of benefits upon consultation between the employee's physician and the employer's medical representative.

Subsection (d) provides that any employee who is aggrieved by a violation of this section may apply to the Secretary of Labor for a review.

Subsection (e) provides that an employee subjected to a violation of this section shall be compensated for lost wages, costs associated with medical monitoring, and costs associated with the bringing of the allegation.

Subsection (f) provides for civil penalties of not less than $1,000 or more than $10,000 for violators of the section as determined by the Secretary of Labor.

Section 9. Enforcement authority

Subsection (a) provides for injunctive relief against anyone engaged in an act or practice constituting a violation of this Act.

Subsection (b) provides that notification does not constitute or affect a claim for compensation, loss, or damage and that neither does notification start the tolling of any statute of limitations with respect to the filing of a timely claim.

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Section 10. Authorizations

Authorized appropriations are $25 million for each of the fiscal years 1987 and 1988.

Section 11. Effective date

Provisions of the Act become effective six months after the date of enactment.

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SUPPLEMENTAL VIEWS ON H.R. 1309

We share the Majority's desire for protecting workers from potentially harmful toxic substances in the workplace. We differ with the Majority not in our commitment to protecting workers but in our view of the best means to provide such protection. H.R. 1309 provides too little information to adequately protect workers, and provides it too late. For example, it does little but increase anxiety to inform industrial workers who have already been exposed to a hazardous material that they are in a population at risk because, instead of sharing the general 10-in-1,000,000 likelihood of contracting some particular illness, they now have a 13-in-1,000,000 risk due to working with the material. The risk computation is so scientifically unsound that it need not even be adjusted for factors that may significantly alter risk (such as diet and smoking), so that the anxiety may be needless.

We support an alternative approach to that of H.R. 1309 in an effort to provide more meaningful, timely, and responsible protection for workers. Our substitute requires that the Department of Labor broaden and strengthen the OSHA Hazard Communication Standard so as to require that employers notify employees of health hazards in the workplace and train those employees in how to handle those hazards safely. These regulations just took effect on May 25, 1986, and we feel that they should be given a chance to work.

This standard covers all hazardous chemicals, including both health hazards (such as liver damage or cancer) and physical hazards (such as flammability and reactivity). A chemical is to be considered a health hazard if there is one positive toxicological study that indicates an adverse health effect. Total coverage has been estimated to be as many as 575,000 hazardous chemical products.

The Hazard Communication Standard currently requires that chemical manufacturers and importers evaluate the hazards of each chemical they produce or import. They then must label each shipped container of a hazardous chemical and prepare and distribute a material safety data sheet (MSDS) containing detailed information on the chemical, including its hazards and the means of protecting workers from those hazards. An MSDS must state the acute and chronic health effects of the chemical, as well as the signs and symptoms of exposure, and any medical conditions that may be aggravated by exposure. In addition, all manufacturing employers must write and implement a hazard communication program. As part of such a program, they must label all containers in the facility, maintain MSDSs and provide their employees with access to them, and train workers about hazards, how to avoid them, and how to obtain and use relevant information.

Our substitute expands the scope of the Hazard Communications Standard to cover all employers rather than just manufacturers.

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Rather than having OSHA enforce the standard in industries where a different federal agency may be already activity involved in implementing other health and safety programs, our substitute permits cooperative agreements to facilitate implementation by the appropriate agency for each industry.

In another significant change from current law, the alternative requires that employers provide former workers, upon request, a list of workplace health hazards. Since some states already require such a procedure, this provision would have the beneficial effect of making the protection uniform for all American workers. Former employees could use this information to take appropriate health precautions. The existence of this important new right of former workers would be communicated by public service announcements prepared and distributed by the Department of Labor. The effectiveness of public service announcements was demonstrated by the federal Black Lung program, where worker notification by public service announcements lead to over $2 billion in claims.

Our substitute provides tougher penalties for violators of the Hazard Communication standard. Specifically, the failure of an employer to make a hazard determination, to have a written communication program, to label properly or otherwise provide required warnings, to record required information on an MSDS, or to establish and conduct an employee training and information program would be treated as a serious violation under the OSHA law. Willful violations creating a substantial probability of serious physical harm would be punishable by a fine of $25,000 for the first offense and $50,000 thereafter. Criminal penalties are provided for willful violations resulting in dealth and knowingly making false statements on MSDSs. Employees are given explicit statutory protections against employment discrimination for having exercised their rights under the law.

Finally, employers are required to provide information and training to current employees regarding workplace health hazards. The training must emphasize the chronic and acute health effects associated with such hazards in a manner promoting early detection and treatment. To bolster this training, the National Institution for Occupational Safety and Health is directed to conduct research into improving surveillance, monitoring, and treatment of employees exposure to occupational health hazards.

Through our substitute, we require that employers notify workers of hazards before exposure occurs so that proper precaution can be taken rather than having the government notify those determined to be at risk after exposure. It should be noted in this respect that a "hazard" is an intrinsic property of a substance, whereas "risk" is tied to the degree of exposure. Our substitute requires information be provided to employees when they are potentially exposed to a hazard. This is much broader protection than requiring only that they be notified when they are at increased risk of developing a disease. In other words, we seek to put a guardrail at the top of the cliff rather than to park an ambulance at the bottom of the cliff.

Employers know the impacted workers and will have an incentive to provide added precautions once they must give notice and provide training regarding occupational health hazards. The notice

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can be provided in a manner and at a time so as to increase safety without encouraging litigation. In this respect, while a representative from the Justice Department testified before the subcommittee that H.R. 1309 would result in increased liability litigation, Assistant Attorney General John R. Bolton wrote to Congressman Thomas E. Petri that, "it is the Department's assessment that your draft substitute would result in perhaps significantly less tort litigation than H.R. 1309." This is of critical concern at this time of exploding tort liability. Congress should not be contributing to the current costly litigation crisis by enacting H.R. 1309 at the same time we are trying to combat the crisis with other legislation.

Further, our substitute avoids the complicated, if not impossible, task of having the federal government identify individuals who are at risk of occupational disease. Under H.R. 1309, this responsibility would result in the creation of a costly new federal agency within the Department of Health and Human Services. Burdening the federal government with this novel, complex duty of risk assessment could subject it and all taxpayers to the risk of tort liability for errors in both assessment and notification not withstanding the language in H.R. 1309.

The Hazard Communication standard took effect less than two months ago. By building on that standard with our substitute, we seek to protect employees from health hazards in the workplace through pre-exposure notification and training. This approach should be given a fair opportunity to work before we add a complex, costly, and untested program of post-exposure risk assessment and notification.

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MINORITY VIEWS ON H.R. 1309

The Minority members of this committee strongly support workers' right to know of the hazards in their workplace and believe that all precautions should be taken to minimize those hazards.

The Minority members believe that the prevention of injury or illness is the ultimate goal of workers' notification of workplace hazards.

The disagreement, however, is whether H.R. 1309 will, as the opening sentence of this report contends, result in "reducing and, eventually, eliminating death and disability caused by diseases resulting from exposures to toxic substances and processes in the workplace." There are no requirements in H.R. 1309 that would result in the lowering of permissible exposure levels (PELs) for asbestos, benzene, ethylene oxide, or any other potentially hazardous substance. There are no provisions in H.R. 1309 that would require engineering controls or personal protective equipment to protect workers from hazardous levels of potentially harmful substances. There are no provisions in H.R. 1309 that would require employees to be trained in the safe handling of any potentially harmful substance. These types of provisions would be necessary in any legislation if the required result is disease prevention. All H.R. 1309 would do is (1) notify the worker that the bladder cancer he could have may have resulted from his occupation and (2) recommend medical monitoring or evaluation.

DEFINITION OF "POPULATION AT RISK"

The definition uses a rate of 30%—that is, if the disease occurs in an exposed population at a rate of 30% greater than in a population not exposed, then that group is at increased risk of disease. The major problem with using a 30% excess risk factor is that it is an arbitrary and inflexible figure, making it too unscientific to be reliable for cause-and-effect decision making. Simple numerical excess is only one criterion used in determining the cause of disease. Confounding factors, the differences between exposed and non-exposed populations, such as diet and cigarette smoking, to name a few, are not considered.

Unsuccessful efforts were made by the Minority prior to full committee markup to improve this provision and during markup to amend this section so that scientists serving on the Risk Assessment Board would be allowed to use their expertise in developing criteria that would be statistically significant for determining the risk of each case.

The unwillingness of the Majority members on this one important issue will result in notification based on bad science, making H.R. 1309 even less capable of achieving the desired results of notifying workers who may be at risk of disease. Most scientists agree

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that the 30 percent trigger is too low (some epidemiological studies use a 200 percent to 400 percent excess) and that it will result in unnecessary notification to many who are not at risk and exclude many who are at risk.

INDIVIDUAL NOTIFICATION

This bill has been described as "a simple measure." It is anything but. The process of identifying individuals would be lengthy and tedious. According to NIOSH, four major steps are involved:

First, identify the producers of the substance. This is achieved by having someone review such possible sources as—

Chemical Week Buyers Guide;

EPA's TSCA file (Currently much of this information may be confidential; however, it is supposed to include all manufacturers who produce 1000 kg/year or more of a given substance.);

Stanford Chemical Economics handbook (Stanford Research Institute); and

Groups that collect material safety data sheets (e.g., Information Handling Service).

Second, identify the users of the substance. This would involve tracking the substance as it goes from the producer to its final use or disposal and investigating intermediate stops along the way.

Third, determine which employees among the users of the substance may have been exposed, and determine whether the potential exposure may have been hazardous. NIOSH would probably have to rely a great deal on employers to determine if the workers were exposed. Determining the extent of exposures would be, for practical purposes, impossible in most cases.

Fourth, establish vital status for all employees who were potentially exposed, and locate current addresses for those who are still living.

Social Security records;
Internal Revenue Service records;
Post office and State records;
Other possible sources;
Contract with a private "locating service."

The problems with the notification as required in H.R. 1309, according to NIOSH, are several. There would be a lack of exposure information needed to prevent many false notifications from occurring. This would require a huge resource effort, and there is no requirement that the system for counseling, medical surveillance and treatment be in place and available to meet the needs of the notified workers.

In a June 11, 1986, letter to Chairman Hawkins opposing the legislation, Secretary Bowen, of the Department of Health and Human Services, states—

> The technical feasibility of notifying each individual in populations "at risk," especially if the individuals have not been included in any Departmental study, is questionable. Furthermore, the costs of attempting such an effort are considerable for a few of the larger populations that might be notified, such as asbestos-exposed workers, the costs may be as high as hundreds of millions of dollars.

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LIMITED BENEFITS OF NOTIFICATION

The Majority makes unsubstantiated claims regarding the benefits of H.R. 1309. The Majority report states the obvious when it declares "that prevention and early detection of cancer are the most significant means of eliminating it from society," but it fails to note that only 5 percent of cancers in our society are occupationally related and therefore impacted by this legislation. Of this number, fewer than half could be helped by medical intervention. As the Majority report notes, NIOSH has identified as many as 250,000 workers at risk of occupational diseases and has determined that 140,000 of these workers could not be helped by medical intervention.

CREATION OF FIFTY HEALTH CENTERS

The bill requires that the Secretary "establish and certify" ten health centers the first year and "additional health centers" to obtain no less than one per State not more than five years after enactment. The Secretary is to select these centers from among educational resource centers of NIOSH and similar facilities and other private and governmental organizations that may apply. NIOSH's preliminary cost estimates regarding the establishment of these health centers finds that:

> Each of the initial ten centers would require at least four full-time professionals for notification-related activities. These would include a physician, a clinic referral coordinator, a special services professional, and a director of medical training activities (estimated cost is $250,000 per year).
>
> In addition, they would need funding for the training efforts ($100,000 for five courses per year) and for research efforts related to these activities ($250,000 for a modest effort in this area). This would total $600,000 plus 50% overhead, for a total of $900,000 per center. Thus, the initial 10 centers could cost approximately $9 million per year.
>
> The other 40 centers would require more modest budgets for notification support. Assuming support for base staff and training activities of $250,000 per year, these other centers would require $10 million per year. This would include funding for a clinical coordinator, a training professional, and a part-time physician. Alternatively, they could be provided only base support as a referral center for approximately $50,000 per year, or a total of $2 million per year for these additional centers.

The need for these health centers and the expenditures of these federal dollars during this austere time has not been demonstrated. The few hearings held on H.R. 1309 brought forth no testimony to indicate that current hospitals or medical clinics are incapable of medically monitoring or evaluating notified workers.

The Minority members believe that existing hospitals are capable of dealing with the medical needs of notified workers and that

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this provision will result in unnecessary expenditure of scarce federal dollars.

PUBLIC REVIEW OF BOARD'S RECOMMENDATION

H.R. 1309 was amended during Full Committee markup to allow for public comment and hearing on the Risk Assessment Board's proposed findings and recommendations.

The Secretary shall adopt the findings and recommendations of the Board unless the Secretary determines that proper procedures were not followed or that to do so would endanger the health or safety of a class or category of workers.

We also believe that the public's rights for a hearing should be available at the final phase in the process, that is, upon the Secretary's determination. Are we denying individuals their due process rights by not allowing them to participate in government decisions that ultimately affect those individuals.

COSTS TO EMPLOYERS

The rising costs of health care is an issue of national importance. Any employing entity—be it private business, federal, State, or local governments—is very concerned about these costs, as most employers provide health care benefit plans to their employees. As a result of an effort to keep down the cost to employers and employees, the majority of health care benefit plans have decreased its coverage.

H.R. 1309 requires that employers provide for medical testing, monitoring an evaluation of notified employees. The cost must be borne by the employer except where no portion of exposure occurred at the employees current place of employment, then the employer may pass the cost along to the employee.

The cost of providing for this coverage will substantially increase the cost of the health care benefit plans. In light of the testimony by the insurance industry, it is doubtful that such coverage will be made available to employers or their employees. In the case of an employer whose profit margin is small, it could be the deciding factor in a business permanently closing its doors.

Industry is responding to employee safety and health concerns. Engineering controls are being used. Personal protection equipment is being made available. Warning labels on hazardous substances are in place. Also, workers are being trained and educated regarding the proper handling of hazardous substances.

Another cost item is the very real potential for litigation. It is difficult to believe that H.R. 1309 would not affect litigation. A NIOSH pilot notification study proved that notification results in litigation. The study, done to provide NIOSH with information on the issues involved in notifying workers at high risk of disease, was initiated in 1979, and the cohort at-risk was considered as all hourly employees of the Augusta Chemical Company between 1940 and 1972 (about 1385 persons). Approximately 800 of those persons were notified that they may have been exposed to betanapthylamine (BNA) and hence may be at elevated risk of bladder cancer. Once notification had been achieved, $335 million in lawsuits were

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filed against an already bankrupt company. In its Interim Report #1 on this notification study, NIOSH stated—

> Many of the lawsuits appear to be by people with no evidence of bladder cancer. Numerous workers with prostate disease have expressed concern . . . in community meetings that other diseases, particularly prostate disease and brain tumors, were due to BNA exposure. In another situation the NIOSH project officer was deposed by an attorney (for a worker) who maintained that BNA caused his client's brain tumor. In the deposition it was stated that there is no known link in the literature.

The NIOSH report goes on to state—

> The implications of this study . . . are striking. At the present, individual notification of former employees who were subjects of epidemiological record studies is not customarily done. If this study is seen as a precedent, there could be increased pressure on investigators to notify individual subjects. This could result in drastic changes in the type and cost of subsequent epidemiological studies. If previous studies are now found to merit notification, whole segments of agencies and institutions would have to spend time on such efforts. *The impact, in terms of litigation, would be staggering.* An orderly resolution to this problem is imperative. For these reasons there is a need for the following: (1) a resolution of the technical matters relating to individual notification, (2) criteria for what constitutes a *notifiable risk,* and (3) development of a societal solution for the problem of compensation and funding for on-going medical surveillance [emphasis added].

H.R. 1309 is not an orderly solution to the litigation problem but is more likely an additional burden to an already overburdened tort system. Other committees in the House and Senate are diligently attempting to solve the liability crisis, and we as national legislators must consider the impact that enactment of H.R. 1309 would have in this area. The testimony of the Justice Department and the insurance industry regarding the potential for increased litigation should not be ignored.

ADMINISTRATION AND ENFORCEMENT OF H.R. 1309

Another flaw of H.R. 1309 is the placement of the administration of the program within the Department of Health and Human Services and the enforcement authority placed in the Department of Labor. It would seem to make better sense to have one agency administer and enforce the program. Because the Labor Department has greater experience in worker safety and health, we believe that it should be the administering and enforcing agency.

FEDERAL COSTS OF H.R. 1309

The bill has an unrealistic authorization level of $25 million for the direct cost of legislation.

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NIOSH estimates that notification would cost between $33–$55 per worker. Notification of workers exposed to lead, NIOSH estimates, would cost between $32 million and $44 million.

The governmemt would also be responsible for 50 health care centers, which would cost about $19 million per year. Research activities required under the bill would cost about $5 million per year. The hot line would cost $55,000 per year.

H.R. 1309 would burden the federal government with the complex task of assessing risk of occupational disease and then notifying untold numbers of often difficult-to-locate workers. Failure at any point in this new responsibility could subject the government or its employees to tort litigation from dissatisfied persons for alleged errors in risk assessment or notification.

In addition, the federal government is included in the definition of employer and would therefore be responsible for providing for payment of medical monitoring and evaluation should its employees be notified that they are at risk.

The authorization level is horribly deficient, and we believe that there will be great pressure to drive the cost upward.

We can no longer continue to legislate regardless of cost when deficit spending has reached over $200 billion and other economic indicators show that our national debt has reached $2.3 trillion. For the first time in our history, we have become a debtor nation.

CONCLUSION

We urge our colleagues to reject this ill-conceived bill which creates an impossible task of individual notification and an impracticable solution to the problem of disease prevention.

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INDIVIDUAL VIEWS OF HON. MARGE ROUKEMA

I am strongly in favor of H.R. 1309. I firmly believe that employees exposed to hazardous substances on the job are entittled to the individual notification that they may be at risk of contracting a disease which this legislation requires. I further believe that the medical monitoring program set out in the bill is crucial for both the prevention of disease and, where that is not possible, the treatment of disease at an early stage.

I represent a district in New Jersey, which is the most densely populated state in the nation. In addition, it leads the nation in the percentage of workers employed in chemical manufacturing and is the leading state for pharmaceutical manufacture. For these reasons, New Jersey under the strong leadership of Republican Governor Tom Kean, has enacted a "Worker and Community Right to Know Act" which has been called the most protective of employees of any such state legislation that exists. Thus, the state has wisely made the determination that notifying workers of their exposure to harmful substances in the workplace is of crucial importance. I agree with that determination and believe that H.R. 1309 is an important supplement to New Jersey's own law. At the same time, this legislation does not threaten states such as New Jersey which choose to enact their own stringent laws with preemption.

MARGE ROUKEMA.

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